MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

00319

Reg. Dist. No. 14

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 1 1/2 yr
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 325 S. Furrow St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Gladys Rebecca Adams

4. DATE OF DEATH (Month) (Day) (Year) Jan 21 1950

5. SEX F.
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH Mar 1909
9. AGE last birthday 40 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher
10b. KIND OF BUSINESS OR INDUSTRY Candy
11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John E Adams
14. MOTHER'S MAIDEN NAME Albie Creamer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service) NONE
16. SOCIAL SECURITY NO. ?
17. INFORMANT Helen Virginia Adams

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uremia	unknown
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Congenital polycystic kidneys	
	(c) — bilateral	life

757.1
57e

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pituitary tumor, undiagnosed unknown

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 7, 1948 to Jan 21, 1950 that I last saw the deceased alive on Jan 21, 1950 and that death occurred at 3 P m., from the causes and on the date stated above.

SIGNATURE W. H. Martin (Degree or title) M.D. ADDRESS Sykesville Md DATE SIGNED Jan 21/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Jan. 25, 1950
NAME OF CEMETERY OR CREMATORY Loudon Park
LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REG.
REGISTRAR'S SIGNATURE Mr. C. Harry Weer
24. FUNERAL DIRECTOR George L. Schwab ADDRESS 2101 Frederick Ave. Baltimore, Maryland

496 x 2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

RECEIVED
JAN 21 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06320

Reg. Dist. No. 71

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Uniontown Rural
LENGTH OF STAY (in this place): 3 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Uniontown Rural

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Uniontown (Rural)
STREET ADDRESS (If rural, give location): Uniontown (Rural)

3. NAME OF DECEASED (Type or Print): (First) ELLA (Middle) CRAIG (Last) ANDREWS

4. DATE OF DEATH: (Month) Jan (Day) 13 (Year) 1950

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: May 5 1866

9. AGE last birthday: 85 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Wm Craig

14. MOTHER'S MAIDEN NAME: Lydia Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Mrs R L Sebastian, Westminster Md Rural

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a): Congestive Pneumonia

Antecedent cause(s) (b): Chronic Myocarditis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c):

422.2
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 7, 1949, to Jan 13, 1950, that I last saw the deceased alive on Jan 13, 1950, and that death occurred at 8:30 a m, from the causes and on the date stated above.

SIGNATURE (Degree or title): J H Legg M D — ADDRESS: Union Bridge — DATE SIGNED: 1-13-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Jan 16 1950 — NAME OF CEMETERY OR CREMATORY: Arlington — LOCATION (City, town, or county) (State): Upper Dairby, Penna

DATE REC'D BY LOCAL REG.: January 13 50 — REGISTRAR'S SIGNATURE: Margaret P. England

24. FUNERAL DIRECTOR — ADDRESS: D D Hartsler & Sons, Union Bridge & New Windsor, Md

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JAN 17 1950
BUREAU U. S.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

00321

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton — LENGTH OF STAY (in this place): 1 yr. 3 mos. 14 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Sana.	STREET ADDRESS (If rural, give location): 1105 E. Madison Street ✓

3. NAME OF DECEASED (Type or Print)	(First) WALTER	(Middle)	(Last) ARGENT	4. DATE OF DEATH	(Month) January	(Day) 28	(Year) 1950
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: Sept. 28, 1908	9. AGE last birthday: 41 yrs.	If under 1 year: Months. Days	If under 24 hrs.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dry Clearner	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Fayettesville, N. Carolina	12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME: Walter Argent	14. MOTHER'S MAIDEN NAME: Callie Smith						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY No.: 212-14-3986	17. INFORMANT AND ADDRESS: Deceased					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	May, 1948
002 Antecedent cause(s)		
13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 14, 1948, to Jan. 28, 1950, that I last saw the deceased alive on Jan. 28, 1950, and that death occurred at 4:35 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M. D.		Henryton, Md.	1/28/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 2-1-50	NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem	LOCATION (City, town, or county): A. A. Co.	(State): Md.
DATE REC'D BY LOCAL REG.: 1/28/50	REGISTRAR'S SIGNATURE: Albert R. Swanhaus Deputy Local	24. FUNERAL DIRECTOR: Byron & Mamie Wright	ADDRESS: 721 Augusta St. Balto. Md.	

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RECEIVED
FEB 2 1950
BUREAU V. S.

00322

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY Carroll Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (in this place) 24 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 27 Westmoreland St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural give location) 27 Westmoreland St.

3. NAME OF DECEASED (Type or Print) (First) LYDIA (Middle) ESTELLA (Last) BROWN
4. DATE OF DEATH (Month) Jan. (Day) 15 (Year) 1950
5. SEX female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed
8. DATE OF BIRTH Dec. 12, 1874
9. AGE last birthday 75 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Adams Co. Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Spangler
14. MOTHER'S MAIDEN NAME Lucy Hoffman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO. X
17. INFORMANT Mrs. W. Warfield Babylon

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Carcinoma of lung.	6 weeks.
170 Antecedent cause(s)		
50 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of breast	2 years.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 3/10/48
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/2, 1948, to 1/15, 1950, that I last saw the deceased alive on 1/15, 1950, and that death occurred at 7 40 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Fletcher Bare
ADDRESS Westminster, Md.
DATE SIGNED 1/15/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 1/17/50
NAME OF CEMETERY OR CREMATORY Reformed Cemetery
LOCATION (City, town, or county) (State) Taneytown Carroll Co. Md.
DATE REC'D BY LOCAL REG. 1/16/50
REGISTRAR'S SIGNATURE L. Woodward
24. FUNERAL DIRECTOR J. E. Myers Jr. Westminster, Md.
ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 19 1950
BUREAU V. S.

00323

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY: CARROLL MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural-Sykesville — LENGTH OF STAY (in this place): 20 yrs., 1 mo 24 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Hampstead
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	(First) BESSIE	(Middle) Ruth	(Last) BURKE	4. DATE OF DEATH	(Month) 1 (Day) 30 (Year) 1950
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 8/19/1899	9. AGE last birthday: 50 yrs.	If under 1 year: Months. Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Baltimore County, Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: John Seaks	14. MOTHER'S MAIDEN NAME: Minnie Meryman				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS: Record, Springfield State Hospital			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Tuberculosis, chronic fibrotic, ā cavitation — More than 3 years

002x Antecedent cause(s)

13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenia, catatonic type — 24 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/6, 1947, to 1/30, 1950, that I last saw the deceased alive on 1/30, 1950, and that death occurred at 7:00 A EST m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Henry C. A. Neal	M. D.	Sykesville, Maryland	1/30/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb 1/1950	Grace	Balto Co Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 30, 1950	O. Harry Weer	Edna C. Tipton, Hampstead Md	

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 1 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

00324

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton; LENGTH OF STAY (in this place) 5 mos. 16 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Sana.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore-30, Md.; STREET ADDRESS (If rural, give location) 1240 S. Sharp Street. ✓

3. NAME OF DECEASED (Type or Print): (First) MORTIMER (Middle) CLIFFORD (Last) CAMPBELL

4. DATE OF DEATH: (Month) Jan. (Day) 10 (Year) 19 50

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Jan. 23, 1904

9. AGE last birthday: 45 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Jamaica, West Indies

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Campbell

14. MOTHER'S MAIDEN NAME: Agatha Walker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY No.: 212-09-6733

17. INFORMANT AND ADDRESS: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — Sept., 1947

002X

Antecedent cause(s)

131

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 25, 1949, to Jan. 10, 1950, that I last saw the deceased alive on Jan. 10, 1950, and that death occurred at 12:15 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Reuben Hoffman, M.D. ADDRESS: Henryton, Md. DATE SIGNED: 1/10/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE: 1/13/50 NAME OF CEMETERY OR CREMATORY: Mt Calvary LOCATION (City, town, or county) (State): A A Co Md

DATE REC'D BY LOCAL REG.: 1/10/50 REGISTRAR'S SIGNATURE: Albert R. Swankhaus Deputy Local

24. FUNERAL DIRECTOR: Isaac L Brown Son ADDRESS: 108 W Montgomery St

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RECEIVED
JAN 11 1950
BUREAU V. S.

SEARCH RESERVED FOR BINDING

00325

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH· COUNTY: CARROLL MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE: MARYLAND COUNTY: CARROLL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: RURAL SYKESVILLE — LENGTH OF STAY (in this place): 65 YRS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: RURAL SYKESVILLE
HOSPITAL OR INSTITUTION OR STREET ADDRESS: ROUTE 1	STREET ADDRESS (If rural give location): ROUTE 1

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)		
MARY	ELLEN	CONAWAY	JANUARY	11	1950		
5. SEX: FEMALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH: FEB. 26, 1860	9. AGE last birthday: 89 yrs.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE	10b. KIND OF BUSINESS OR INDUSTRY: NONE	11. BIRTHPLACE (State or foreign country): MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME: EPHRIAM TRIPLETT	14. MOTHER'S MAIDEN NAME: MARY E. LOWE						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO — (If year, give war or dates of service) —	16. SOCIAL SECURITY NO.: NONE	17. INFORMANT: VERNON C. CONAWAY					

18. MEDICAL CERTIFICATION

DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Hypertensive cardiovascular disease,

443 Antecedent cause(s) (b) with anterioscleroris & myocarditis

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Senile changes

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1935, 19....., to 11 January 1950, that I last saw the deceased alive on 10 January 1950, and that death occurred at 2:15 A.m., from the causes and on the date stated above.

SIGNATURE: W. H. Lawson (Degree or title) M.D. ADDRESS: Sykesville, Maryland DATE SIGNED: 1/11/50

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL	DATE: 1/13/50	NAME OF CEMETERY OR CREMATORY: PROVIDENCE CEM.	LOCATION (City, town, or county): GAMBER	(State): MD.
DATE REC'D BY LOCAL REG.: 1/11/50	REGISTRAR'S SIGNATURE: [signature]	24. FUNERAL DIRECTOR: J. FRANCIS REESE	ADDRESS: WESTMINSTER, MD.	

MARGIN RESERVED FOR BINDING

PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 12 1950
BUREAU V.

00326

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville LENGTH OF STAY (in this place) since 4-9-48	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital	STREET ADDRESS (If rural give location) R.F.D. # 3 ✓

3. NAME OF DECEASED (Type or Print)	(First) Luther	(Middle) Meador	(Last) Cornwall	4. DATE OF DEATH	(Month) Jan	(Day) 27	(Year) 1950
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH 11-10-1881	9. AGE last birthday 68 yrs.	If under 1 year Months	Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book store owner	10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) Washington D.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Luther Meador Cornwall	14. MOTHER'S MAIDEN NAME Maude Hepburn						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service) --	16. SOCIAL SECURITY NO. -----	17. INFORMANT Records of Springfield State Hospital					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral arteriosclerosis	4 years
334 Antecedent cause(s)		
97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) general arteriosclerosis	more than 4 yrs
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Psychosis with cerebral arteriosclerosis	4 years

19a. DATE OF OPERATION -----	19b. MAJOR FINDINGS OF OPERATION -----	20. AUTOPSY? Yes ☒ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify) -----	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	(CITY OR TOWN) ----- (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) ----- m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? -----

22. I hereby certify that I attended the deceased from June 3, 1948, to Jan. 27, 1950, that I last saw the deceased alive on Jan. 27, 1950, and that death occurred at 10.20 p.m., from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. (Degree or title) ADDRESS Sykesville, Md DATE SIGNED 1-27-50

Martin Gross, M.D.

23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE Jan. 28, 1950	NAME OF CEMETERY OR CREMATORY Washington D.C.	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. Jan. 28, 1950	REGISTRAR'S SIGNATURE O. Harry Weer	24. FUNERAL DIRECTOR J. Wm. Lee's Sons	ADDRESS Washington D.C.

24691

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
FEB 1 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00327

CERTIFICATE OF DEATH

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead; LENGTH OF STAY (in this place) 30 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS S. Main St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead Md; STREET ADDRESS (If rural give location) S. Main St

3. NAME OF DECEASED (Type or Print): (First) Grace (Middle) May (Last) DAVIDSON

4. DATE OF DEATH: (Month) January (Day) 9 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 2-12-1900

9. AGE last birthday: 49 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife, Factory worker

10b. KIND OF BUSINESS OR INDUSTRY: Home; Sewing Factory

11. BIRTHPLACE (State or foreign country): Mt Lusby Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry S. Switzer

14. MOTHER'S MAIDEN NAME: Lena Clas.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO. 216-14-5875

17. INFORMANT: Earl Davidson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Haemorrhage — Interval Between Onset and Death: 48 hrs.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertensive Cardio-Renal Vascular Disease — 15 yrs

(c)

4428 12a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1938, to Jan 9, 1950, that I last saw the deceased alive on Jan 9, 1950, and that death occurred at 16 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Joseph E Bush M D — ADDRESS Hampstead Md — DATE SIGNED 1-9-50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE Jan 12-50 — NAME OF CEMETERY OR CREMATORY Mosley — LOCATION (City, town, or county) Carroll Co (State) Md

DATE REC'D BY LOCAL REG. Jan. 11, 1950 — REGISTRAR'S SIGNATURE John S. Hughes Jr

24. FUNERAL DIRECTOR Edw C Tipton — ADDRESS Hampstead Md

196 44

RECEIVED
JAN 12 1950
BUREAU V. S.

00328

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville | LENGTH OF STAY (in this place) since 8/11/39
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Montg.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
STREET ADDRESS (If rural give location) 221 Holly Avenue

3. NAME OF DECEASED (Type or Print): (First) Frank (Middle) Lewis (Last) EAKLE
4. DATE OF DEATH: (Month) Jan. (Day) 16 (Year) 19 50

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: 5/12/1901
9. AGE last birthday: 48 yrs. | If under 1 year: Months — Days — | If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telephone elec. engineer
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: George Eakle
14. MOTHER'S MAIDEN NAME: Margaret J. Kirkpatrick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown | (If yes, give war or dates of service) ---
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT: Records - Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Peritonitis, paralytic ileus — 1 day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Gastric ulcer, (perforated recently) — about 2 yrs.
(c)

540.1
30b

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. General paresis — 11 yrs.

19a. DATE OF OPERATION: ---
19b. MAJOR FINDINGS OF OPERATION: ---
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ---
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ---
(CITY OR TOWN): ---
(COUNTY):
(STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour): --- m.
INJURY OCCURRED While at Work ☐ — Not While At work ☐
HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from April 1, 1948, to Jan. 16, 1950, that I last saw the deceased alive on Jan. 16, 1950, and that death occurred at 2:20 a.m., from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. (Degree or title) — ADDRESS Sykesville, Maryland — DATE SIGNED 1/16/50

Martin Gross, M.D.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 1/16/50 | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State): Washington D.C.

DATE REC'D BY LOCAL REG.: Jan. 17, 1950 | REGISTRAR'S SIGNATURE: C. Harry Weer

24. FUNERAL DIRECTOR: John Lee Sons Co | ADDRESS: Washington DC

V1855

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JAN 19 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

00329

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton
LENGTH OF STAY (in this place): 4 mos. 28 da.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Sana.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore-1
STREET ADDRESS (If rural, give location): 766 W.Lexington Street ✓

3. NAME OF DECEASED (Type or Print): (First) BESSIE (Middle) LEONA (Last) FISHER

4. DATE OF DEATH: (Month) January (Day) 3 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Sep.

8. DATE OF BIRTH: January 15, 1919

9. AGE last birthday: 30 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Rocky Mountain, N. C.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Lewis Duggans

14. MOTHER'S MAIDEN NAME: Maggie McDowell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Tuberculosis — Interval between onset and death: December, 1948

Antecedent cause(s)

002X

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

13b

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 5, 1949, to Jan. 3, 1950, that I last saw the deceased alive on Jan. 3, 1950, and that death occurred at 5:30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Reuben Hoffman, M.D. ADDRESS: Henryton, Md. DATE SIGNED: 1/3/50

23. BURIAL, CREMATION / REMOVAL (Specify): Shipped DATE: 1-6-50 NAME OF CEMETERY OR CREMATORY: Rockey Mount N. C LOCATION (City, town, or county) (State): Rocky mountain N.C

DATE REC'D BY LOCAL REG. 1/3/50

REGISTRAR'S SIGNATURE: Albert R. Swanhaus Deputy Local

24. FUNERAL DIRECTOR: Mrs Katie R. Williams ADDRESS: 322 N. Schroeder St. 52076

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JAN 11 1950
BUREAU V. S.

00330

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH· COUNTY: CARROLL MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE: Maryland COUNTY: ~~Baltimore~~
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural - Sykesville; LENGTH OF STAY (in this place): 4 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Unknown
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Sykesville, Maryland	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	(First) RICHARD	(Middle) ALOYSIUS FITZGERALD	(Last)	4. DATE OF DEATH	(Month) 1 (Day) 29 (Year) 1950
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 11/18/10	9. AGE last birthday: 39 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Jersey City, New Jersey	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: Richard Fitzgerald		14. MOTHER'S MAIDEN NAME: Mary Sherry			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If year, give war or dates of service): Unknown	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS: Record, Springfield State Hospital			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
002X Immediate cause	(a) Pulmonary Tuberculsosis	unknown
Antecedent cause(s)		
13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/25/, 1950, to 1/29, 1950, that I last saw the deceased alive on 1/29/, 1950, and that death occurred at 4:15 P EST m., from the causes and on the date stated above.

SIGNATURE: Henry C. Mead (Degree or title) M.D. ADDRESS: Sykesville, Maryland DATE SIGNED: 1/29/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY: University of Md. Medical Board - Anatomy	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. 2-9-50	REGISTRAR'S SIGNATURE: A. H. Hedrich	24. FUNERAL DIRECTOR: g. Anatomy Board Md. Medical Board	ADDRESS

98899

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

00331

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH: COUNTY CARROLL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN NEW WINDSOR
LENGTH OF STAY (in this place) 2 WEEKS
HOSPITAL OR INSTITUTION OR STREET ADDRESS UNIONTOWN ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY BALTIMORE
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN TIMONIUM
STREET ADDRESS (If rural give location) ✓

3. NAME OF DECEASED (Type or Print) (First) PENELOPE (Middle) PRICE (Last) FRANCIS

4. DATE OF DEATH (Month) JANUARY (Day) 21, (Year) 1950

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH AUG. 17, 1874
9. AGE last birthday 75 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY AT HOME
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME R. OLIVER PRICE
14. MOTHER'S MAIDEN NAME ELLA ROYSTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT THOMAS W. FRANCIS - TIMONIUM, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinomatosis

174X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Adenocarcinoma, uterus

48b (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/7, 1950, to 1/21, 1950, that I last saw the deceased alive on 1/21, 1950, and that death occurred at 4 30 A m., from the causes and on the date stated above.

SIGNATURE M. E. Robertson (Degree or title) M.D. ADDRESS New Windsor, Md. DATE SIGNED 1/21/50

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF JAN. 23, 1950
NAME OF CEMETERY OR CREMATORY CLYNMALAIRE CEMETERY
LOCATION (City, town, or county) (State) MYLADY'S MANOR, BALTO. CO., MD.

DATE REC'D BY LOCAL REG. Jan. 23, 1950
REGISTRAR'S SIGNATURE Ernie S Burdett
24. FUNERAL DIRECTOR JOHN BURNS' SONS, TOWSON, MD. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 26 1950
BUREAU V. S.

00332

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (in this place) 10 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 22 E. Green St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) 22 E. Green St.

3. NAME OF DECEASED (Type or Print): (First) Annie (Middle) E. (Last) Gable
4. DATE OF DEATH: (Month) Jan. (Day) 17 (Year) 1950

5. SEX: Female
6. COLOR OR RACE: White-Caucasian
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 4-1880
9. AGE last birthday: 69 yrs. If under 1 year: Months, Days. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John E. Rickle
14. MOTHER'S MAIDEN NAME: Mary E. Harman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT AND ADDRESS: ~~Jacob~~ Gable 22 E. Green St. Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral hemorrhage — Interval between onset and death: 12 hrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

331 K
83a

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cardiac failure — 2 years

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August, 1948, to Jan 17, 1950, that I last saw the deceased alive on Jan 16, 1950, and that death occurred at 12:40 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
Julius Chaffo, M.D. | 88 W Main Westminster Md | Jan 17, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Buried | DATE: Jan. 19-1950 | NAME OF CEMETERY OR CREMATORY: St John Cemetery | LOCATION (City, town, or county): Green St. Westminster | (State): Md.

DATE REC'D BY LOCAL REG.: 1/18/50 | REGISTRAR'S SIGNATURE: H. Lee Waesche

24. FUNERAL DIRECTOR: C. Bankard Dox | ADDRESS: Westminster, Md.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 19 1950
BUREAU V. B.

00333

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 83

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH — COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Morgan
LENGTH OF STAY (In this place): 54 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Morgan
STREET ADDRESS (If rural, give location): Rural-- Woodbine

3. NAME OF DECEASED (Type or Print): (First) SANKEY (Middle) (Last) Gartrell
4. DATE OF DEATH: (Month) Jan. (Day) 2, (Year) 1950
5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 3-7-1877
9. AGE last birthday: 72 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Trackman
10b. KIND OF BUSINESS OR INDUSTRY: B. & O. R.R.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY:
13. FATHER'S NAME: Aaron Gartrell
14. MOTHER'S MAIDEN NAME: Elizabeth Gosnell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT AND ADDRESS: Mrs. Mollie P. Gartrell, Woodbine, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Pulmonary oedema	1 da
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardiac Decompensation	2 wks
422.2 93d	(c) Chronic Myocarditis	2 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Bronchial Asthma	? years

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 31, 1949, to Jan 2, 1950, that I last saw the deceased alive on Jan 2, 1950, and that death occurred at 11:35 P.m., from the causes and on the date stated above.
SIGNATURE: Stanley Grabill — M.D. (Degree or title) ADDRESS: Mt Airy - Md DATE SIGNED: 1/3/50

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE: 1-5-1950 — NAME OF CEMETERY OR CREMATORY: Morgan Chapel — LOCATION (City, town, or county) (State): Carroll Co. Md.
DATE REC'D BY LOCAL REG.: Jan 4-50 — REGISTRAR'S SIGNATURE: Ina M. Hewitt
24. FUNERAL DIRECTOR: C. M. Waltz, Winfield, Md. ADDRESS

VS. A15

26647

RECEIVED
JAN 6 1950
BUREAU V. S.

00334

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eldersburg; LENGTH OF STAY (in this place) 7 years
   HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Carroll
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eldersburg
   STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Richard (Middle) Mordesi (Last) Gist

4. DATE OF DEATH: (Month) January (Day) 15, (Year) 1950

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: Oct. 28, 1875

9. AGE last birthday: 74 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Joseph M. Gist

14. MOTHER'S MAIDEN NAME: Mary Gist

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) N (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs Daisy Ward Gist - Sykesville Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral hemorrhage — Interval between onset and death: 5:10 min.

260 x 61 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Hypertensive Cardiovascular disease with Arteriosclerosis 2042.
(c) Diabetes Mellitus 1542.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1935, 19..., to 15 Jan, 1950, that I last saw the deceased alive on 15 Jan, 1950, and that death occurred at 12:15 P. m., from the causes and on the date stated above.

SIGNATURE C. H. Lawrence (Degree or title) M. D. ADDRESS Sykesville DATE SIGNED 1/15/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF 1-17-50 | NAME OF CEMETERY OR CREMATORY Springfield | LOCATION (City, town, or county) Sykesville, Md. (State)

DATE REC'D BY LOCAL REG. Jan. 16, 1950 | REGISTRAR'S SIGNATURE C. Henry Weer | 24. FUNERAL DIRECTOR C. H. Weer | ADDRESS Sykesville, Md.

30869

RECEIVED
JAN 19 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00335

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll County — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Manchester — LENGTH OF STAY (in this place): 2 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Long View Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Upperco
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) HERBERT (Middle) L (Last) HALL

4. DATE OF DEATH: (Month) January (Day) 5 (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Dec. 27, 1866

9. AGE last birthday: 83 yrs. — If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman - Retired

10b. KIND OF BUSINESS OR INDUSTRY: Troy Sunshade Co.

11. BIRTHPLACE (State or foreign country): Bangor, Maine

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Epriam H. Hall

14. MOTHER'S MAIDEN NAME: Myra S ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Lincoln Norcott Hall, Upperco, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Uraemia	3 weeks
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Congestive Heart failure (arteriosclerosis)	1 year
450.0 93d	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1948, to Jan 5, 1950, that I last saw the deceased alive on Jan. 4, 1950, and that death occurred at 2:30a m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Samuel C. Porterfield, M.D. — ADDRESS: Hampstead, Md — DATE SIGNED: 1-5-50

23. BURIAL, CREMATION, REMOVAL (Specify): removal — DATE: 1/5/50 — NAME OF CEMETERY OR CREMATORY: Seneca Falls, N. Y. — LOCATION (City, town, or county) (State): Seneca Falls, New York

DATE REC'D BY LOCAL REG.: 1/5/50 — REGISTRAR'S SIGNATURE: A.W. Hedrick

24. FUNERAL DIRECTOR — ADDRESS: Wm. Cook, Inc., 1217 St. Paul Street

27810

MARYLAND STATE DEPARTMENT OF HEALTH

00336

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 78

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural New Windsor
LENGTH OF STAY (in this place): 60 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural
STREET ADDRESS (If rural, give location): New Windsor

3. NAME OF DECEASED (Type or Print): (First) GEORGE (Middle) W. (Last) HAMMOND

4. DATE OF DEATH: (Month) JAN. (Day) 28 (Year) 1950

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: 7-7-1871

9. AGE last birthday: 78 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John F. Hammond

14. MOTHER'S MAIDEN NAME: Diannah Graham

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Ernest Hammond, New Windsor, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arteriosclerotic C-V Disease — Interval Between Onset and Death: 7 yrs.

Antecedent cause(s)

422.1 93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at after 12 midnight, from the causes and on the date stated above.

SIGNATURE: James T. Marriott (Degree or title) Deputy Medical Examiner ADDRESS: Westminster Md DATE SIGNED: 1-28-50

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE: 1-31-1950 — NAME OF CEMETERY OR CREMATORY: Fairview — LOCATION (City, town, or county) (State): Carroll Co. Maryland

DATE REC'D BY LOCAL REG.: 1-30-50 — REGISTRAR'S SIGNATURE: E. M. Farver

24. FUNERAL DIRECTOR: C. M. Waltz — ADDRESS: Winfield, Md.

E. M. Farver

00000

RECEIVED
FEB 3 1950
BUREAU V. S.

Evidence for change of age shown on:
FILM No. G 123 JAN 11 1950

00337

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY CARROLL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SYKESVILLE
LENGTH OF STAY (in this place) 28 YRS +
HOSPITAL OR INSTITUTION OR STREET ADDRESS SPRINGFIELD STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE CITY
STREET ADDRESS (If rural give location) 3328 EDMONDSON AVE

3. NAME OF DECEASED (Type or Print) (First) ELIZABETH (Middle) (Last) HECK
4. DATE OF DEATH (Month) Jan (Day) 1 (Year) 1950
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE
8. DATE OF BIRTH 1 July 1866
9. AGE last birthday 83 ~~88~~ yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME CHARLES HECK
14. MOTHER'S MAIDEN NAME CATHERINE REIDINGER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY No. UNK.
17. INFORMANT REGORDS SPRINGFIELD STATE HOSP

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) ~~ACUTE~~ CHRONIC MYOCARDITIS AND MYOCARDIAL DEGENERATION	48 HRS
422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(b) ARTERIOSCLEROSIS	10 YRS +
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. INVOLUTIONAL MELANCHOLIA 30 YRS +

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 11, 1937, to Jan 1, 1950, that I last saw the deceased alive on 1 Jan, 1950, and that death occurred at 11:00 P.m. from the causes and on the date stated above.

SIGNATURE Ellis S. Margolin (Degree or title) M.D. ADDRESS Sykesville, Md. DATE SIGNED Jan. 1, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Jan. 4/50
NAME OF CEMETERY OR CREMATORY Loudon Park Cem.
LOCATION (City, town, or county) Baltimore (State) Md.
DATE REC'D BY LOCAL REG. 1/3/50
REGISTRAR'S SIGNATURE D.W. Hedrick DM
24. FUNERAL DIRECTOR Inamie Cook Syfer ADDRESS 1600 W. North ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00338

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH · COUNTY: CARROLL · STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: MARYLAND · COUNTY: CARROLL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: WESTMINSTER · LENGTH OF STAY (in this place): 20 YRS.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: WESTMINSTER
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 114 LIBERTY ST.	STREET ADDRESS (If rural, give location): 114 LIBERTY ST.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ALINE	WALKER	HINDS	JAN.	14	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
FEMALE	WHITE	WIDOW	OCT. 10, 1868	81 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	NONE	VIRGINIA	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
H. H. WALKER	BETTY BERRY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
NO	—	NONE	LOUISE HINDS, WESTMINSTER, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Cerebral Hemorrhage	Unknown
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	None	
(c)	None	

331X
330

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 14, 1950, to Jan 14, 1950 that I last saw the deceased alive on Jan 14, 1950, and that death occurred at 6:30 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Julius Clapp M.D.		88 W Main	Westminster Md. Jan 14, 1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
BURIAL	JAN. 16, 1950	WESTMINSTER CEMETERY	WESTMINSTER	MD.

DATE RECD. BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/16/50	[signature]	J. FRANCIS REESE	WESTMINSTER, MD.

RECEIVED
JAN 19 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00339

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton; LENGTH OF STAY (in this place) 1 mo. 21 da.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Charles; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bryan's Road; STREET ADDRESS (If rural, give location) Bryan's Road, ✓

3. NAME OF DECEASED (Type or Print): (First) STEVEN (Middle) JOHN (Last) HOLLEY

4. DATE OF DEATH: (Month) January (Day) 12 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: July 5, 1945

9. AGE last birthday: 4 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Washington D.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph H. Holley

14. MOTHER'S MAIDEN NAME: Evelyn Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Joseph Holley, Bryan's Road, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Tuberculous Menigitis	Sept., 1949
0104 Antecedent cause(s)		
14 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 22, 1949, to Jan. 12, 1950, that I last saw the deceased alive on Jan. 12 1950, and that death occurred at 6:25 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Reuben Hoffman, M.D. Henryton, Maryland 1/12/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE 1-16-50 | NAME OF CEMETERY OR CREMATORY Metropolitan Mem. Cem. | LOCATION (City, town, or county) (State) Pomonkey, Md

DATE REC'D BY LOCAL REG. 1/12/50 | REGISTRAR'S SIGNATURE Albert R. Swanham, Deputy Local | 24. FUNERAL DIRECTOR Barnes & Matthews | ADDRESS 614-4" St. SW Washington, D.C.

RECEIVED
JAN 21 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00340

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
LENGTH OF STAY (in this place) 40 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 127 Liberty St. Ex Ad

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
STREET ADDRESS (If rural, give location) 127 Liberty St.

3. NAME OF DECEASED (Type or Print) (First) Minnie (Middle) May (Last) Holmes

4. DATE OF DEATH (Month) Jan. (Day) 9 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH July 5 - 1870
9. AGE last birthday 79 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Fred. Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Solomon Pfoutz
14. MOTHER'S MAIDEN NAME Mary Susan Naill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Jacob T. Holmes 127 Liberty St. Westminster, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma Colon — INTERVAL BETWEEN ONSET AND DEATH 1 yr. 75

153 ✓ Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

46e (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar, 1949, to Jan 9, 1950, that I last saw the deceased alive on Jan 8, 1950, and that death occurred at 12:30 P.m., from the causes and on the date stated above.

SIGNATURE James T. Marsh (Degree or title) MD ADDRESS Westminster Md DATE SIGNED 1/10/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Jan. 12. 1950
NAME OF CEMETERY OR CREMATORY Deer Park Cemetery
LOCATION (City, town, or county) Westminster Rural (State) Md.

DATE REC'D BY LOCAL REG. 1/11/50
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR H Bankard & Son, Westminster Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 12 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

not Rec 00341

CERTIFICATE OF DEATH

Reg. Dist. No. 34

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville; LENGTH OF STAY (In this place) 10yrs, 9 months; HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Balto.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore, Md.; STREET ADDRESS (If rural give location) 7809 Bagley Avenue

3. NAME OF DECEASED (Type or Print)	(First) David	(Middle) Clarence	(Last) Hopkins	4. DATE OF DEATH	(Month) 1	(Day) 1	(Year) 1950
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH 3-4-1880	9. AGE last birthday 69 yrs.	If under 1 year Months	Days	If under 24 hrs. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) shirt-cutter, night watchman	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME David C. Hopkins		14. MOTHER'S MAIDEN NAME Emma Hopkins
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
17. INFORMANT Records of Springfield State Hospital		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic myocarditis and myocard. degeneration with decompensation.	1 mo
422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(b) arteriosclerosis	10 yrs
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Psychosis with cerebral arteriosclerosis	10 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1 September 1947 to Jan. 1, 1950, that I last saw the deceased alive on 1-1-1950, 1950, and that death occurred at 10-25 p.m., from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. (Degree or title) ADDRESS Sykesville, Md DATE SIGNED Jan. 2, 1950

Martin Gross, M.D.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/4/50	Loudon Park Cem.	Balto., Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 3, 1950	M.W. Hedrick	WM. J. TICKNER & SONS	Balto., Md.

60206

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00342

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH — COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville
LENGTH OF STAY (in this place): 11mo. 10da.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
STREET ADDRESS (If rural, give location): Dividing Creek Road, Arnold P.O. ✓

3. NAME OF DECEASED (Type or Print): (First) Ernest (Middle) James (Last) Howard
4. DATE OF DEATH: (Month) Jan. (Day) 12 (Year) 50
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 12-13-09
9. AGE last birthday: 40 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: Fitter
11. BIRTHPLACE (State or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William Howard
14. MOTHER'S MAIDEN NAME: Dora Evans
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — 1yr 1 mo

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Psychosis with syphilitic meningo-encephalitis — 5 yrs.

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death: duodenal ulcer — 1 yr

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-2, 19 49, to Jan. 12, 19 50, that I last saw the deceased alive on Jan. 12, 19 50, and that death occurred at 11:15 A. m., from the causes and on the date stated above.

SIGNATURE: M. Virginia Beyer- M.D. (Degree or title) — ADDRESS: Sykesville Md — DATE SIGNED: 1-12-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Jan 18 1950 — NAME OF CEMETERY OR CREMATORY: Pineville — LOCATION (City, town, or county) (State): Kentucky

DATE REC'D BY LOCAL REG.: Jan. 16, 1950 — REGISTRAR'S SIGNATURE: C Harry Weer

24. FUNERAL DIRECTOR: C H Weer · Sykesville Md — ADDRESS

H1699

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JAN 17 1950
BUREAU F. S.

00343

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH · COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Dorchester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton — LENGTH OF STAY (in this place): 1yr. 10 mos. 3days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cambridge
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Hospital	STREET ADDRESS (If rural, give location): Egypt Rd.

3. NAME OF DECEASED (Type or Print)	(First) BEATRICE	(Middle)	(Last) HUMANE	4. DATE OF DEATH	(Month) Jan. 1 (Day) 18 (Year) 1950
5. SEX: Female	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: Aug., 25, 1908	9. AGE last birthday: 41 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Factory Worker	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country): Cambridge, Maryland	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Palestine Plater			14. MOTHER'S MAIDEN NAME: Martha Dixon		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO	(If year, give war or dates of service)	16. SOCIAL SECURITY No.: 214-12-6763	17. INFORMANT AND ADDRESS: Deceased		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — January, 1947

002X Antecedent cause(s)

13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 15, 1948, to Jan., 18 1950, that I last saw the deceased alive on Jan., 18, 1950, and that death occurred at 1:45 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Walter Hoffman, M.D.		Henryton, Maryland	1/18/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 1-22-50	NAME OF CEMETERY OR CREMATORY: Cambridge Gen	LOCATION (City, town, or county) (State): Cambridge Md.
DATE REC'D BY LOCAL REG.: 1/18/50	REGISTRAR'S SIGNATURE: Albert R. Swankham	24. FUNERAL DIRECTOR: Herbert St Clair	ADDRESS: Cambridge Md.

Deputy Local

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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JAN 21 1950
BUREAU V. S.

00344

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton — LENGTH OF STAY (in this place): 2 mos. 5 das	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore-17
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Sana.	STREET ADDRESS (If rural, give location): 1314 Myrtle Avenue

3. NAME OF DECEASED (Type or Print)	(First) GEORGE	(Middle) WILLIAM	(Last) HUMBLES	4. DATE OF DEATH	(Month) January (Day) 14 (Year) 1950
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Sep.	8. DATE OF BIRTH: October 13, 1901	9. AGE last birthday: 48 yrs.	If under 1 year: Months. Days — If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Appomattox Co., Virginia	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME: David Humbles	14. MOTHER'S MAIDEN NAME: Georgie Thornhill				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY No.: 216-10-5844	17. INFORMANT AND ADDRESS: Deceased			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — Sept., 1949

002X Antecedent cause(s)

13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 11, 1949, to Jan. 14, 1950, that I last saw the deceased alive on Jan. 14, 1950, and that death occurred at 8:00 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Rubien Hoffman, M.D.		Henryton, Md.	1/14/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 1-14-50	NAME OF CEMETERY OR CREMATORY: Lincoln Mem. Cem.	LOCATION (City, town, or county) (State): Southland, Md.
DATE REC'D BY LOCAL REG.: 1/14/50	REGISTRAR'S SIGNATURE: Albert Swankhaus	24. FUNERAL DIRECTOR: L. E. Murray Sor.	ADDRESS: 1337-10th St N.W. Wash. D.C. 75099

Deputy Local

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 21 1950
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

00345

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH: Carroll
County.....
City or town.....Millers
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....10 yrs
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....—

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....Maryland..... County.....Carroll
City or town.....Millers, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....—

3.(a) FULL NAME Christian Frederick Hunt

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
~~F~~ M.	W	Widowed

6.(b) Name of husband or wife.....Ida Condelia
6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) Nov 24 - 1872

8. AGE: Years 77 | Months 1 | Days 12 | If less than one day .....hrs. .....min.

9. Birthplace.....Manchester, Carroll, Md.
(Town, county, and state)

10. Usual occupation.....— Farmer

11. Industry or business

FATHER
12. Name.....Christian Frederick Hunt
13. Birthplace.....Germany

MOTHER
14. Maiden name.....— Del Cathemire ?
15. Birthplace.....Germany

16. Informant.....Mrs. Lawrence Fuller
Address.....Millers, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-7-50 (month) (day) (year)
Cemetery or crematory.....Cemetery
Location.....Manchester Md.

18. Funeral director.....Jacob Winkelmann Sons
Address.....Manchester Md.

19. Jan 6th 1950 Mrs. W. P. S. Deaver
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Jan 5.....1950, at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1949 to Jan 1950
and that I last saw h/M alive on Jan 4 1950

Immediate cause of death	DURATION
Cerebral hemorrhage	2 days
Due to Arteriosclerotic Heart	
Due to Disease	
Other conditions	
420.0	
93d (Include pregnancy within 3 months of death)	

Major findings of operations.....Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide.....Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury.....Injured at work?

23. SIGNATURE W. H. Foard M.D
M. D. or other
Address.....Manchester, Md Date signed 1/6/50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
JAN 13 1950
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00346

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton
LENGTH OF STAY (in this place) 15 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 1,
STREET ADDRESS (If rural, give location) 754 W. Franklin St.,

3. NAME OF DECEASED (Type or Print) (First) THOMAS (Middle) EDWARD (Last) JOHNSON

4. DATE OF DEATH (Month) Jan., (Day) 21 (Year) 1950

5. SEX Male
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Sep.
8. DATE OF BIRTH July 22,1920
9. AGE last birthday 29 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James I. Johnson
14. MOTHER'S MAIDEN NAME Mary L. Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. 216-609-4317
17. INFORMANT AND ADDRESS Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	Oct., 1949
002X Antecedent cause(s)		
13/- Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 6, 1950, to Jan., 21, 1950, that I last saw the deceased alive on Jan., 21, 1950, and that death occurred at 5:30 A. m., from the causes and on the date stated above.

SIGNATURE Nathan Mofman, M.D. (Degree or title) ADDRESS Henryton, Maryland DATE SIGNED 1/21/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 1-26-50
NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.
LOCATION (City, town, or county) Baltimore, Md. (State)

DATE REC'D BY LOCAL REG. 1/21/50
REGISTRAR'S SIGNATURE Albert R. Swankham
24. FUNERAL DIRECTOR Katie L. Williams - 322 N. Schroeder ADDRESS

Deputy Local

98899 Salto, Md.

RECEIVED
JAN 25 1950
BUREAU V. S.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00347

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton
LENGTH OF STAY (in this place) 8 mos. 2 days.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Sana.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Wicomoco
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury, Maryland
STREET ADDRESS (If rural, give location) 409 Delaware Street.

3. NAME OF DECEASED (Type or Print) (First) ESTHER (Middle) DOREEN (Last) JOLLY

4. DATE OF DEATH (Month) January (Day) 15, (Year) 1950

5. SEX Female
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH April 16, 1929
9. AGE last birthday 20 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Salis bury, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Emerson M. Jolly
14. MOTHER'S MAIDEN NAME Esther White

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. 216-20-3965
17. INFORMANT AND ADDRESS Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	Dec., 1947
002X Antecedent cause(s)		
13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 13, 1949, to Jan. 15, 1950, that I last saw the deceased alive on Jan. 15, 1950, and that death occurred at 6:30 P.m., from the causes and on the date stated above.

SIGNATURE Reuben Hoffman M.D. (Degree or title) ADDRESS Henryton Maryland DATE SIGNED 1/15/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 1-19-50
NAME OF CEMETERY OR CREMATORY Princess Anne
LOCATION (City, town, or county) Princess Anne (State) Md

DATE REC'D BY LOCAL REG. 1/15/50
REGISTRAR'S SIGNATURE Albert Swankhorn
24. FUNERAL DIRECTOR Norma J. Ward - Marion Station ADDRESS Md.

Deputy Local

XV491

RECEIVED
JAN 17 1950
BUREAU V. S.

00348

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton — LENGTH OF STAY (in this place) 1yr. 22 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 1.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital	STREET ADDRESS (If rural, give location) 716 Sarah Ann Street

3. NAME OF DECEASED (Type or Print)	(First) MURIEL	(Middle) AMY	(Last) JONES(CEPHAS)	4. DATE OF DEATH	(Month) Jan.,	(Day) 6	(Year) 1950
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Feb., 10,1924	9. AGE last birthday 25 yrs.	If under 1 year Months.	Days	If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Walter Stansbury		14. MOTHER'S MAIDEN NAME Rebecca Howard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS Deceased	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — Aug., 1948

002 X Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

136 (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec., 14, 1948, to Jan., 6, 1950, that I last saw the deceased alive on Jan. 6, 1950, and that death occurred at 6: A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.		Henryton, Maryland	1/6/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 1-10-50	NAME OF CEMETERY OR CREMATORY Mt Auburn	LOCATION (City, town, or county) Balto	(State) Md.
DATE REC'D BY LOCAL REG. 1/6/50	REGISTRAR'S SIGNATURE Albert R. Susanbhaus	24. FUNERAL DIRECTOR William A Jackson	ADDRESS 916 Penna ave	

Deputy Local

XX44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 11 1950
BUREAU V. S.

Evidence for addition of #18 shown on:

06349

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

FILM No. G 124 FEB 20 1950

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton; LENGTH OF STAY (in this place) 4days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 1,
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital	STREET ADDRESS (If rural, give location) 689 W. Mulberry St.,

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
MARY		KENNARD	January	10	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	Negro	Sep.	May 30, 1909	40 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Chestertown, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Kennard	Eleanora Black

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No		Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Unknown Pulmonary tuberculosis (2/15/50 akc)	unknown
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 6, 1950, to Jan. 10, 1950, that I last saw the deceased alive on Jan. 10, 1950, and that death occurred at 2:55 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.	Henryton, Maryland	1/10/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/14/50	Mt Auburn Cem.	Balto. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/10/50	Albert R. Swankhaus Deputy Local	Mrs Katie R. Williams per Herman West.	322 N Schroeder St

RECEIVED
JAN 17 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

00350

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fuzzelburg; LENGTH OF STAY (in this place) 50 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fuzzelburg; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) THEODORE (Middle) F (Last) LAMBERT

4. DATE OF DEATH: (Month) Jan (Day) 2 (Year) 1950

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W

8. DATE OF BIRTH: April 3 1872

9. AGE last birthday: 77 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: ✓

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Lambert

14. MOTHER'S MAIDEN NAME: Angeline Wolf

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY No.: ✓

17. INFORMANT: Mrs Alice Fleb Ringer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Arterio-sclerotic Cardio Vascular Renal Disease c Hypertension	5 yrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Mild Diabetes	
	(c) Prostatic Hypertrophy c Cystitis	2 yrs.

260 X
61

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION: 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: INJURY OCCURRED While at Work ☐ Not While At work ☐: HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1949, to Jan 2, 1950, that I last saw the deceased alive on Dec 31, 1949, and that death occurred at 6:10 A m., from the causes and on the date stated above.

SIGNATURE: W Glenn Speicher (Degree or title) ADDRESS: Westminster Md DATE SIGNED: 1/2/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: 1-5-50; NAME OF CEMETERY OR CREMATORY: Hampstead; LOCATION (City, town, or county): Carroll Co; (State): Md

DATE REC'D BY LOCAL REG.: 1/4/50; REGISTRAR'S SIGNATURE: [illegible]; 24. FUNERAL DIRECTOR: Edes Tipton; ADDRESS: Hampstead Md

VS. A15

RECEIVED
JAN 6 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00351

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH — COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westminster — LENGTH OF STAY (in this place): 53 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 53 E. Church St.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westminster
STREET ADDRESS (If rural, give location): 53 E. Church St.

3. NAME OF DECEASED (Type or Print): (First) Emma (Middle) Elizabeth (Last) Magin
4. DATE OF DEATH: (Month) Jan. (Day) 17 (Year) 1950
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: April 10-1896
9. AGE last birthday: 53 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: David E. Currens
14. MOTHER'S MAIDEN NAME: Mary E. Hawk
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT AND ADDRESS: John Magin 53 Church St Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Glioma of frontal lobe of Brain — about 6 mo.

193 X Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

54a (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: 10-5-49
19b. MAJOR FINDINGS OF OPERATION: Glioma of frontal lobe
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify): no
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Sept. 1st, 1949, to 1-17, 1950, that I last saw the deceased alive on 1-16, 1950, and that death occurred at 9 15 P. m., from the causes and on the date stated above.

SIGNATURE: T. L. Billingslea (Degree or title) M.D. — ADDRESS: Westminster, Md. — DATE SIGNED: 1-18-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Jan. 20-1950 — NAME OF CEMETERY OR CREMATORY: Westminster Cemetery — LOCATION (City, town, or county): Westminster, (State) Md.

DATE REG'D BY LOCAL REG.: 1/18/50 — REGISTRAR'S SIGNATURE: [signature] — 24. FUNERAL DIRECTOR: H Bankard & Son — ADDRESS: Westminster, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 19 1950
BUREAU V. S.

00352

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WESTMINSTER
LENGTH OF STAY (in this place) 74 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 164 W. MAIN

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD. COUNTY CARROLL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WESTMINSTER
STREET ADDRESS (If rural, give location) 164 W. MAIN

3. NAME OF DECEASED (Type or Print) (First) HELEN (Middle) MYRLE (Last) MALEHORN
4. DATE OF DEATH (Month) JAN. (Day) 30 (Year) 1950
5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE
8. DATE OF BIRTH OCT. 25: 1875
9. AGE last birthday 74 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME ANDREW JACKSON MALEHORN
14. MOTHER'S MAIDEN NAME ELLEN B. KOONTZ
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service)
16. SOCIAL SECURITY No. NONE
17. INFORMANT AND ADDRESS FLORENCE MALEHORN, WESTMINSTER, MD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) — Coronary disease

420.1 Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH: 7 mos.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 30 1949 to Jan 30, 1950, that I last saw the deceased alive on Jan 28, 1950, and that death occurred at about 5 a.m., from the causes and on the date stated above.

SIGNATURE Reese Wilkens (Degree or title) M.D. ADDRESS 7 Carroll Westminster DATE SIGNED 2/1/50

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE FEB. 1. 1950
NAME OF CEMETERY OR CREMATORY WESTMINSTER CEM.
LOCATION (City, town, or county) Church St. Westminster (State) Md.
DATE REC'D BY LOCAL REG. 2/1/50
REGISTRAR'S SIGNATURE L. Anwodwood
24. FUNERAL DIRECTOR H Bankard Son, Westminster, Md. ADDRESS

XUX99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 6 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

00353

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton
LENGTH OF STAY (in this place) 8mos. 21 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Harford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Aberdeen,
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
GILLIAM		MILES	Jan.,	16	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months.	Days	If under 24 hrs. Hours	Min.
Male	Negro	Single	Mar., 11,1911	38 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Suffolk, Virginia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Miles	Sarah Riddick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
No		Lost	Decease

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	Mar., 1949
Antecedent cause(s)		
002		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
13	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Apr. 25, 1949 to Jan., 16, 1950 that I last saw the deceased alive on Jan., 16, 1950, and that death occurred at 8:25 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Reuben Wolfman, M.D. ADDRESS Henryton, Maryland DATE SIGNED 1/16/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/19/50	Mt Calvery	Druid Hyn Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/16/50	Albert R. Swankhaus	Elroy C Wilson	1000 Brantly Ave

Deputy Local

98894

RECEIVED
JAN 17 1950
BUREAU V. S.

00354

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 7X

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9,18,49.

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 9.18.49.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Balto

City or town: 2207 Sparrow Point Rd.
(If outside city or town limits, write RURAL and give nearest town)

Street No. ..... (If rural, give LOCATION)

2.(a) If veteran, name war ..... ✓

3. (a) FULL NAME Robert Moser

3. (b) Social Security Number

4. Sex: m.

5. Color or race: white

6.(a) Single, married, widowed, or divorced: single

6.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 26 - 1911

8. AGE: 38 Years | Months: 2 | Days: 2 | If less than one day ..... hrs. ..... min.

9. Birthplace: Patterson, N.Jersey
(Town, county, and state)

10. Usual occupation: factory worker - on a bar saw

11. Industry or business

FATHER
12. Name: Adolph Moser
13. Birthplace: Switzerland

MOTHER
14. Maiden name: H elen Teischman
15. Birthplace: Germany

16. Informant: Adolph Moser
Address: 2207 Sparrows Point Rd., Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 31-1950 (month) (day) (year)

Cemetery or crematory: Sacred Heart Cemetery

Location: O'Donnell Str. Rd.

18. Funeral director: John G. Connelly

Address: 418 Eastern Ave.

19. 1/31 1950 (Date rec'd by registrar) W.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 28 1950, at 1.30p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9.18. 1949, to Jan 28 1950 and that I last saw him alive on Jan. 28 1950

Immediate cause of death: ~~Rheumatic~~ Cardiac Decompensation — DURATION: 6 weeks

Due to: Rheumatic mitral heart dis. — years

Due to: .....

Other conditions: Pulmonary Tuberculosis — about 1 year
410x
(Include pregnancy within 3 months of death)
13b

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Elizabeth A. Winiarz M.D.

Address: Springfield State Hospital, Md. Date signed: 1.28.50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

002

00355

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH — COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville — LENGTH OF STAY (in this place): 13 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): unknown

3. NAME OF DECEASED (Type or Print): (First) Alice (Middle) Certrude (Last) Nelson
4. DATE OF DEATH: (Month) January, (Day) 10, (Year) 1950

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 12-3-1888
9. AGE last birthday: 61 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: unknown
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William K Nelson
14. MOTHER'S MAIDEN NAME: Alice Bartholomew

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown — (If year, give war or dates of service):
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Broncho-pneumonia — 3 days

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
260 X 61
(b) Cerebral hemorrhage due to hypertesnive cardio-vascular disease — about 2½ years
(c) diabetes mellitus — known 13 years

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.
Paranoid condition — about 15 years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-2, 1942, to 1-9, 1950, that I last saw the deceased alive on 1-9-, 1950, and that death occurred at 1.10 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Irene L. Hildebrand, M.D. — ADDRESS: Springfield State Hospital — DATE SIGNED: 1-10-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Jan 11th 1950 — NAME OF CEMETERY OR CREMATORY: Mt Olivet — LOCATION (City, town, or county) (State): Baltimore, Md.

DATE REC'D BY LOCAL REG.: Jan 10-50 — REGISTRAR'S SIGNATURE: A. W. Hedrick

24. FUNERAL DIRECTOR: Wm. J. Tickner & Sons. — ADDRESS: N& Pa Aves

XUK99

00356

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 13 yr 11 mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Balto
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Middle River
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Elsie (Middle) Marie (Last) Roesner
4. DATE OF DEATH (Month) Jan (Day) 25 (Year) 1950

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single
8. DATE OF BIRTH Jan 21-11
9. AGE last birthday 39 yrs. If under 1 year Months Days 4 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Roesner
14. MOTHER'S MAIDEN NAME Pauline Espanner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Henry Roesner

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Abscess of left lung	?
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Epilepsy	14 yrs
	(c)	

3533
85

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 16, 1936, to Jan 25, 1950, that I last saw the deceased alive on Jan 25, 1950, and that death occurred at 8-45 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
J. J. Martin M.D. Sykesville Jan 25-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Jan. 26, 1950
NAME OF CEMETERY OR CREMATORY Moreland Memorial Park
LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REG. Jan. 26, 1950
REGISTRAR'S SIGNATURE C. Harry Weer
24. FUNERAL DIRECTOR Kossahn Funeral Home
ADDRESS 7401 Belair Rd. Balto. 6, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 1 1950
BUREAU V. S.

00357

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: --
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville — LENGTH OF STAY (in this place): since 9/8/42	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital	STREET ADDRESS (If rural give location): unknown

3. NAME OF DECEASED (Type or Print) (First) William	(Middle) -	(Last) ROSKY	4. DATE OF DEATH (Month) January	(Day) 3	(Year) 1950
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widower	8. DATE OF BIRTH: 1879	9. AGE last birthday: 70 ? yrs.	If under 1 year: Months - Days - If under 24 hrs.: Hours - Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer	10b. KIND OF BUSINESS OR INDUSTRY: farming	11. BIRTHPLACE (State or foreign country): Virginia	12. CITIZEN OF WHAT COUNTRY? United States		
13. FATHER'S NAME: William Rosky		14. MOTHER'S MAIDEN NAME: Annie Sauer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service) ---	16. SOCIAL SECURITY NO.: unknown	17. INFORMANT: Records - Springfield State Hospital			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Aneurysm of aorta	more than 2 weeks.
024 X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 30a	(b) Syphilis (tabes dorsalis)	12 years.
	(c) Myocardial degeneration	4 years.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pleural effusion — 2 weeks.

19a. DATE OF OPERATION: ---	19b. MAJOR FINDINGS OF OPERATION: ---	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify) ---	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	(CITY OR TOWN) (COUNTY) (STATE) ---
TIME OF INJURY (Month) (Day) (Year) (Hour) --- m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to Jan. 3, 1950, that I last saw the deceased alive on Jan. 3, 1950, and that death occurred at 10:15 p.m., from the causes and on the date stated above.

SIGNATURE Martin Gross, M. D. (Degree or title) — ADDRESS: Sykesville, Maryland — DATE SIGNED: 1/4/50

Martin Gross, M.D.

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: Jan. 6 1950	NAME OF CEMETERY OR CREMATORY: Cedar Hill	LOCATION (City, town, or county): A. A. Co.	(State): Md.
DATE REC'D BY LOCAL REG.: Jan. 5, 1950	REGISTRAR'S SIGNATURE: C. Harry Weer	24. FUNERAL DIRECTOR: Chas. F. Dill	ADDRESS: 1501 E. Fort ave., Balto. Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
JAN 10 1950
BUREAU

00358

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH- COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville LENGTH OF STAY (in this place) since 10/13/36	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield St. Hospital	STREET ADDRESS (If rural give location) 412 East Liberty

3. NAME OF DECEASED (Type or Print)	(First) David	(Middle) ---	(Last) ROWE	4. DATE OF DEATH	(Month) January (Day) 16 (Year) 1950
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) divorced	8. DATE OF BIRTH 1/31/79	9. AGE last birthday 70 yrs.	If under 1 year Months — Days — If under 24 hrs. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill worker	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Washington County, Maryland	12. CITIZEN OF WHAT COUNTRY? United States		
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown (If year, give war or dates of service) ---	16. SOCIAL SECURITY NO. unknown	17. INFORMANT Records - Springfield State Hospital			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Bronchopneumonia	4 days
Antecedent cause(s)		more than
450.0 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	12 years.
107	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Involutional psychosis, paranoid type	12 yrs.

19a. DATE OF OPERATION ---	19b. MAJOR FINDINGS OF OPERATION ---	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify) ---	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) --- m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to Jan. 15, 1950, that I last saw the deceased alive on Jan. 15, 1950, and that death occurred at 4:45 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Martin Gross, M.D.	Martin Gross, M.D.	Sykesville, Maryland	1/16/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR ~~CREMATORY~~	LOCATION (City, town, or county) (State)
Burial	1-19-50	Rest Haven	Hagerstown, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 17, 1950	C. Harry Weer	Scott F. Minnick	Hagerstown, Md.

49699

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
JAN 19 1950
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00359

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY: CARROLL MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Caroline
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural - Sykesville — LENGTH OF STAY (in this place): 6 mo	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Greensboro
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital	STREET ADDRESS (If rural, give location): ✓

3. NAME OF DECEASED (Type or Print)	(First) KATHRYN	(Middle) ELLEN	(Last) SHAFFER	4. DATE OF DEATH	(Month) 1	(Day) 6	(Year) 1950
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M	8. DATE OF BIRTH: 3/12/18	9. AGE last birthday: 31 yrs.	If under 1 year: Months. Days	If under 24 hrs.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse's aide	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Caroline County, Maryland	12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME: Harry L. Roe	14. MOTHER'S MAIDEN NAME: Maymie Smith						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS: Record, Springfield State Hospital					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Bilateral active pulmonary tuberculosis with cavitation	Indefinite
002X Antecedent cause(s)		
13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Schizophrenia, paranoid type	indefinite

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/26/49, 19....., to 1/6/....., 1950, that I last saw the deceased alive on 1/6, 1950, and that death occurred at 2:00 A EST m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Henry C. A. Mead	M. D.	Sykesville, Maryland	1/6/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/9/50	Ridgely	Ridgely Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 6, 1950	A Stanley Wee	R. B. Rawlings	Greensboro, Md

79092

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 10 1950
BUREAU V. S.

00360

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 75

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY CARROLL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL MANCHESTER | LENGTH OF STAY (in this place) 30 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY CARROLL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
CLEO	I.	SLAGLE	JAN	30	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
F	W	MARRIED	APR. 27-1888	61 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	—	MARYLAND	U S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ELIAS SINGER	NOT KNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
NO	NONE	MURRY SLAGLE. HAMPSTEAD R.D. 1.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — 36 hrs.

420.1 Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Jan. 28, 1950, to Jan. 31, 1950, that I last saw the deceased alive on Jan. 31, 1950, and that death occurred at 1:30 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Maurice C. Porterfield	M.D	Hampstead, Md	Jan. 31, 1950

23. BURIAL, CREMATION / REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb. 2. 1950	RIDERS CEMETERY	WESTMINSTER,	MD.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 31/50	Mrs. W. R. J. Benner	H. Bankard & Son,	Westminster, Md.

RECEIVED
FEB 2 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

00361

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 36 W. George

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Pleasant Valley
STREET ADDRESS (If rural, give location) 36 W. George

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Vernon	W	Smith	Jan.	23	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
M	W	married	5/1/1878	71 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired farmer- Frick Co	farm machinery	Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Basil Smith	Frances Chilcote

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	202-20-6785	Mrs. Vernon W. Smith---Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Chronic myocarditis	2 yrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio Sclerosis (General)	5 yrs
(c) Chronic multiple Arthritis	10 yrs.

422.1 93d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from March, 1949, to Jan 23, 1950, that I last saw the deceased alive on Jan 22, 1950, and that death occurred at 2:45A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wm Glenn Speiches		Westminster Md	1/24/50

1/23/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	1/25/50	Meadow Branch	Mr Westminster Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/24/50		C.O.FUSS & SON	Taneytown, Md.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 26 1950
BUREAU V. S.

00362

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Woodbine
LENGTH OF STAY (in this place) 2 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Hewitt Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY County
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodbine - Rural
STREET ADDRESS (If rural, give location) Hewitt Nursing Home

3. NAME OF DECEASED (Type or Print) (First) Charlotte (Middle) Rebecca (Last) Snyder
4. DATE OF DEATH (Month) Jan. (Day) 27 (Year) 1950

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widow
8. DATE OF BIRTH 1-4-1863
9. AGE last birthday 87 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME William Arbaugh
14. MOTHER'S MAIDEN NAME Sarah Stone

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Mrs V. S. Ebaugh Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardio Vascular Renal Disease	Jan 21
442 Antecedent cause(s)	Uremia	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio Sclerosis (Genl)	10 yrs
61	(c) Mild Diabetes	5 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from November 1949, to Jan 27, 1950, that I last saw the deceased alive on Jan 26, 1950, and that death occurred at 9:25 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
McGlenn Speicher Westminster Md 1/28/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Jan. 29-1950
NAME OF CEMETERY OR CREMATORY Bethel Cemetery
LOCATION (City, town, or county) Carrollton (State) Md.

DATE REC'D BY LOCAL REG. 1/28/50
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR H. Bankard Son, Westminster, Md. ADDRESS

XVX99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 30 1950
BUREAU V. S.

00363

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH — COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Flohrville — LENGTH OF STAY (in this place): Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Sandra

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Flohrville
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Sandra (Middle) Carol (Last) Stem
4. DATE OF DEATH: (Month) Jan. (Day) 24 (Year) 1950
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: July 20, 1946
9. AGE last birthday: 3 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Monroe Stem
14. MOTHER'S MAIDEN NAME: Ruth E. Colen
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Monroe Stem, Sykesville Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) cerebral hemorrhage — 2 hours

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) chronic progressive encephalopathy due to birth injury. — 3 1/2 yrs.

(c)

251X
83a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug, 1946, to 24th January, 1950, that I last saw the deceased alive on 24th January, 1950, and that death occurred at 2:45 P.m., from the causes and on the date stated above.

SIGNATURE: W H Sawyer (Degree or title) M.D. — ADDRESS: Sykesville, Md. — DATE SIGNED: 1/24/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Jan. 27 1951 — NAME OF CEMETERY OR CREMATORY: Freedom — LOCATION (City, town, or county) (State): Carroll Co. Md.

DATE REC'D BY LOCAL REG.: Jan. 26, 1950 — REGISTRAR'S SIGNATURE: C Harry Weer — 24. FUNERAL DIRECTOR: C H Weer — ADDRESS: Sykesville, Md.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 1 1950
BUREAU V. S.

00364

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton — LENGTH OF STAY (in this place) 2yrs.2mos. 7days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 24,
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital	STREET ADDRESS (If rural, give location) 5701 Swallow Lane North

3. NAME OF DECEASED (Type or Print)	(First) DOROTHY	(Middle) MAE	(Last) STEVENS	4. DATE OF DEATH	(Month) Jan., (Day) 1, (Year) 1950
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH July 18,1935	9. AGE last birthday 14 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Scholar	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Eastville, Virginia	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Nelson Stevens			14. MOTHER'S MAIDEN NAME Hattie Reed		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS Mrs. Sarah Parker, 5701 Swallow Lane, N.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — Aug.,1947

002Y Antecedent cause(s)

13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 25, 1947, to Jan., 1, 1950, that I last saw the deceased alive on Jan., 1, 1950, and that death occurred at 5:p. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.		Henryton, Md.	1/1/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/4/50	Mt. Auburn Cem.	Baltimore, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/1/50	Albert R. Swankhaus Mad.	Katie R. Williams	

Deputy Local

Per Herman C West

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

RECEIVED
JAN 4 1950
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00365

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY Carroll; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville | LENGTH OF STAY (in this place) since 7/15/49
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) ~~B.~~ & O. YMCA ✓

3. NAME OF DECEASED (Type or Print): (First) Champ (Middle) Henry (Last) STINEBAUGH
4. DATE OF DEATH: (Month) January (Day) 23 rd (Year) 1950
5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): separated
8. DATE OF BIRTH: 10/15/1883
9. AGE last birthday: 66 yrs. | If under 1 year: Months — Days — | If under 24 hrs.: Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10b. KIND OF BUSINESS OR INDUSTRY: B & O R.R.
11. BIRTHPLACE (State or foreign country): Morgan Court, West Virginia
12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME: Daniel Stinebaugh
14. MOTHER'S MAIDEN NAME: ~~XXXXXX~~ Christina Farris
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown | (If year, give war or dates of service) ---
16. SOCIAL SECURITY NO.: 705-05-5331
17. INFORMANT: Records - Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Bronchopneumonia	4 days
Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral hemorrhage	5 days
331X 830	(c) Arteriosclerosis	2½ years
II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.	Psychosis with cerebral arteriosclerosis	about 1 year

19a. DATE OF OPERATION: ---
19b. MAJOR FINDINGS OF OPERATION: ---
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ---
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: ---
(CITY OR TOWN) ---
(COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour): ---
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from Sept. 14, 1949, to Jan. 23, 1950, that I last saw the deceased alive on Jan. 23, 1950, and that death occurred at 3:25 p.m., from the causes and on the date stated above.

SIGNATURE Martin Gross, M. D. (Degree or title) — Martin Gross, M.D.
ADDRESS Sykesville, Maryland
DATE SIGNED 1/23/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 1/26/50
NAME OF CEMETERY OR CREMATORY: Hill Crest Burial Park
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG. Jan. 26, 1950
REGISTRAR'S SIGNATURE C. Harry Weed
24. FUNERAL DIRECTOR: William H. Kight
ADDRESS: Cumberland, Md.

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FEB 1 1950
BUREAU V. S.

00366

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton — LENGTH OF STAY (in this place): 9mos. 23 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 17,
HOSPITAL OR INSTITUTION OR STREET ADDRESS: HENRYTON STATE HOSPITAL	STREET ADDRESS (If rural, give location): 1411 Division St., ✓

3. NAME OF DECEASED (Type or Print)	(First) IRENE	(Middle) GRACE	(Last) (HOWELL) VENABLE	4. DATE OF DEATH	(Month) Jan.,	(Day) 23	(Year) 1950
5. SEX: Female	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: Dec., 6, 1927	9. AGE last birthday: 22 yrs.	If under 1 year: Months. Days	If under 24 hrs.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stock Clerk	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Prince Edward Co., Virginia	12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME: Claude Venable	14. MOTHER'S MAIDEN NAME: Pearl Smith						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: 220-20-5229	17. INFORMANT AND ADDRESS: Deceased					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — Jan., 1949

002 Antecedent cause(s)

13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar., 30, 1950, to Jan., 23, 1950, that I last saw the deceased alive on Jan., 23, 1950, and that death occurred at 9:15 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Nathan Hoffman, M.D.	Henryton, Maryland	1/23/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 1-26-50	NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem.	LOCATION (City, town, or county) (State): Anne Arundel Co. Md.
DATE REC'D BY LOCAL REG.: 1/23/50	REGISTRAR'S SIGNATURE: Albert R. Swankhaus	24. FUNERAL DIRECTOR: Mrs. R. H. Elliott & Dgtr.	ADDRESS: 1129 N. Carolina Balto. Md.

Deputy Local

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 25 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00367

CERTIFICATE OF DEATH

Reg. Dist. No. 50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor Rural
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Marston

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor Rural
STREET ADDRESS (If rural, give location) Marston

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Luther	D	Wantz	Jan	27	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
male	white	married	Nov 16-1868	81 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired farmer		Maryland	US

13. FATHER'S NAME Ezra Wantz

14. MOTHER'S MAIDEN NAME Belinda Brawner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT AND ADDRESS Liggie D Wantz, New Windsor Rural Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Arteriosclerotic - C-V disease — 4 years.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) 422.1 (c) 932

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Nov-, 1949, to Jan 27, 1950, that I last saw the deceased alive on Jan 26, 1950, and that death occurred at 4:00 a m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James A Monroe	M.D.	Westminster Md	1/29/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan 30-1950	St James Cemetery	Hennings Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan 29/1950	Emerie D Benedict	D D Hartzler & Sons	New Windsor & Union Bridge, Md

RECEIVED
JAN 31 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00368

CERTIFICATE OF DEATH

Reg. Dist. No. 7-8

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salem | LENGTH OF STAY (In this place) 95 yrs.?
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salem
STREET ADDRESS (If rural, give location) Rural--Westminster

3. NAME OF DECEASED (Type or Print): (First) LAURA (Middle) T. V. (Last) WILLIAMS
4. DATE OF DEATH: (Month) Jan (Day) 2 (Year) 1950

5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH 6-4-1871 | 9. AGE last birthday 78 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Peter Wolf | 14. MOTHER'S MAIDEN NAME Christina ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. none | 17. INFORMANT AND ADDRESS Reuben B. Williams, Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion — 2 min.

420.1 93d
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cardio-Vascular disease — year.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at 7 P. m., from the causes and on the date stated above.

SIGNATURE James T. Marsh (Degree or title) Deputy Medical Examiner | ADDRESS Westminster Md | DATE SIGNED Jan 3-50

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL | DATE 1-5-1950 | NAME OF CEMETERY OR CREMATORY Trinity Lutheran | LOCATION (City, town, or county) Smallwood, (State) Md.

DATE REC'D BY LOCAL REG. 1-4-1950 | REGISTRAR'S SIGNATURE E. M. Farver

24. FUNERAL DIRECTOR C.M.Waltz, | ADDRESS Winfield, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 9 1950
BUREAU V. S.